

STATE OF NEW HAMPSHIRE INSURANCE DEPARTMENT

INDEPENDENT REVIEW ORGANIZATION CERTIFICATION APPLICATION

Name of Applicant

New License

☐

Renewal License

☐

D/B/A

Street Address

City

State

ZIP

Telephone Number

Name of Chief Executive Officer

Street Address

City

State

ZIP

Telephone Number

Tax Status:

Privately Held

☐

Not-for-Profit

☐

Federal Employer ID #

List states in which applicant is incorporated, licensed, certified or otherwise authorized to conduct business:

We hereby attest to the accuracy of this application

Signature of CEO

Date

Signature of Board Chairman

Date

Notary Public

GENERAL INSTRUCTIONS:

Send the completed application to:

Mary Verville
Examination Division
New Hampshire Insurance Department
56 Old Suncook Road
Concord, NH 03301-7317

Respond to all questions, including attachments, in consecutive order. Submit all requested information except where exceptions are identified. Note: False or misleading statements will result in the loss of certification and/or other action/penalty.

Under NH RSA 420-J:5-d, II, (e), no entity shall be qualified to submit an application if it owns or controls, is owned or controlled by, or exercises common control with any of the following:

- a. a health carrier;
- b. a national, state, or local trade association of health carrier; or
- c. a national, state, or local trade association of health care providers.

Under NH RSA-420-J:5-d, II(e,1-6), no independent review organization, nor any clinical peer reviewer assigned by the independent review organization to conduct the independent review may have a material professional, familial or financial interest in any of the following:

- a. The health carrier that is the subject of the independent review;
- b. Any officer, director, or management employee of the health carrier that is the subject of the independent review;
- c. The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the independent review;
- d. The facility or institution at which the recommended healthcare service or treatment would be provided;
- e. The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the independent review; or
- f. The covered person of the covered person's authorized representative.

In addition, under NH RSA 420-J:5-d, II,(h,1-4), the following entities are not eligible for certification as an independent review organization:

- a. Professional or trade associations of health care providers;
- b. Subsidiaries or affiliates of such provider associations;
- c. Health carrier or health plan associations; and
- d. Subsidiaries or affiliates of health plan or health carrier associations.

I. ORGANIZATION AND MANAGEMENT OF PROPOSED EXTERNAL APPEAL ORGANIZATION:

A. Organizational Structure:

Describe the organizational structure of the proposed Independent Review Organization. An organizational chart should be included with an explanation of the lines of authority. Provide the following documents with any explanations necessary to clarify the meaning or use.

- Certificates of incorporation, articles of organization and by-laws or operating agreement for the Independent Review Organization, holding company or parent entity;
- Organizational chart showing all lines of authority within a holding company or parent subsidiary system;
- List and describe the scope and relationship of all agreements between the applicant and health care services entities, health care providers and management service organizations; and

- Describe the applicant's ability to operate in New Hampshire.

B. Management of Independent Review Organization

- Identify management staff; describe the responsibilities of the staff. The Chief Executive Officer must complete and submit the notarized attestation on conflict of interest, Attachment B, on behalf of all directors, officers, executives and the Medical Director;
- Provide the names of all corporations and organizations owned or controlled by the Independent Review Organization or which owns or controls such organization, and the nature and extent of any such ownership or control;
- Provide the names and biographies of all directors, officers, and executives of the Independent Review Organization, inclusive of the medical director;
- List all potential conflicts as described in NH RSA 420-J:5; and
- Provide an organizational chart showing all lines of authority within the Independent Review Organization.

II. CONTRACTED SERVICE PROVIDERS/CLINICAL PEER REVIEWERS:

- Identify all reviewers in the proposed clinical peer review network. Complete Attachment A and include the name of each reviewer, state license number(s), clinical discipline(s) and research focus where applicable;
- Provide a description for determining the adequacy of the contracted network, including the number of clinical peer reviewers retained by the Independent Review Organization;
- Provide a description of the procedures employed to ensure that clinical peer reviewers conducting independent review are:
 - trained and in compliance with independent review requirements;
 - appropriately licensed, registered or certified;
 - trained in the principles, procedures and standards of the Independent Review Organization; and
 - knowledgeable about the health care service which is the subject of the adverse determination under appeal;
- Provide a description of procedures used to ensure that clinical peer reviewers assigned to review a particular appeal, do not have a prohibited conflict of interest pursuant to RSA 420-J:5-d,II(e); and
- Provide a description of the methods for recruiting and selecting impartial clinical peer reviewers retained by the independent review organization, and for matching such reviewers to specific cases, include a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review.

III. QUALITY ASSURANCE AND CONFIDENTIALITY:

- Provide a description and copy of the quality assurance program established by the Independent Review Organization. This must include written descriptions, to be provided to all individuals involved in such program, of the organizational arrangements and on-going procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in independent reviews performed by the applicant and the mechanisms to ensure the maintenance of program standards;
- Provide a description of the policies and procedures employed to protect the confidentiality of medical and treatment records and review materials in accordance with applicable State and Federal laws; and
- Describe the role of the Medical director, include a description of the Medical Director's expertise to function as such.

IV. APPEAL PROCESS AND INFORMATION SYSTEMS:

Describe all aspects of the appeal process and supporting information systems including:

- Procedures to ensure that both standard and expedited appeals are conducted within the required time frames and any required notices are provided in a timely manner as specified in NH RSA 420-J:5-b and c, and any rule promulgated thereunder;
- Mechanisms through which the Independent Review Organization shall provide ready access to the Insurance Commissioner to all data, records, and information collected and maintained concerning the organization's independent review activities inclusive of any reports the Commissioner determines necessary to evaluate the independent review process;
- Procedures for ensuring that clinical peer reviewers, when making an independent review determination, consider the clinical standards of the health care plan, the information provided concerning the enrollee, the attending physician's recommendation and applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations as required by NH RSA 420-J:5-b,IX;
- A description, and a chart or diagram of the sequence of steps through which an independent review will move from receipt of the independent review by the certified independent review agent through the notification to the enrollee, health plan and the Insurance Department regarding the independent review determination. Such description shall take into account the requirements of NH RSA 420-J:5-b,IX and X;
- Mechanisms for annually reporting the number of independent reviews requested, a description of the independent reviews and the outcomes; and
- Information systems' capability to collect and manipulate data and produce reports on the operations and finances.

V. FINANCIAL ARRANGEMENTS:

- Provide the following current financial data for the applicant:
 - Statement of Revenues and Expenses;
 - Balance Sheet;
 - Methods to repay any indebtedness; sources of capitalization and documentation of accounts, assets, reserves and deposits; and
 - A certified financial statement.
- Submit a list of fees that will be charged for an independent review and an explanation of the methodology used to develop the fee schedule. The fee schedule should include fees for both standard review and expedited review, medical necessity case review and experimental or investigational case review, and single reviewer case review and multiple reviewer case review.

INSTRUCTIONS: Sections VI - VIII should be duplicated and forwarded to each of the following individuals for completion:

- all directors, officers, executives
- the medical director
- all owners

At the end of Section IX is an affidavit that must be completed by each individual listed above. Without all signed and notarized affidavits this application will be considered incomplete.

Omission of any information requested may lead to exclusion of the applicant from consideration for a Certificate of Authority or revocation of the certificate if such certificate is already awarded.

VI. PERSONAL QUALIFYING INFORMATION:**A. PERSONAL INFORMATION:**

NAME (Last)	(First)	(Middle Initial)
-------------	---------	------------------

STREET ADDRESS(residence)

CITY	STATE	ZIP CODE
------	-------	----------

TELEPHONE NUMBER(Area Code)

BUSINESS NAME AND ADDRESS

CITY	STATE	ZIP CODE
------	-------	----------

TELEPHONE NUMBER (Area Code)

DATE OF BIRTH	Month / Day / Year	PLACE OF BIRTH COUNTY/STATE	SOCIAL SECURITY #
---------------	--------------------	-----------------------------	-------------------

CURRENT OR PROPOSED POSITION WITH THE PROPOSED INDEPENDENT REVIEW AGENT

B. INDIVIDUAL EMPLOYMENT HISTORY.

Start with MOST RECENT employment and include employment for the last 10 years. A resume may be included but any additional information requested below and not contained in such a resume should be added. Photocopy and attach additional pages if necessary.

NAME OF EMPLOYER

STREET ADDRESS OF EMPLOYER

CITY	STATE	ZIP CODE
------	-------	----------

DATES OF EMPLOYMENT	TYPE OF BUSINESS
---------------------	------------------

FROM:	TO:
-------	-----

NAME OF SUPERVISOR/REFERENCE	TELEPHONE NUMBER
------------------------------	------------------

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

EMPLOYMENT HISTORY CONTINUED:

NAME OF EMPLOYER

STREET ADDRESS OF EMPLOYER

CITY

STATE

ZIP CODE

DATES OF EMPLOYMENT

TYPE OF BUSINESS

FROM:

TO:

NAME OF SUPERVISOR/REFERENCE

TELEPHONE NUMBER

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

NAME OF EMPLOYER

STREET ADDRESS OF EMPLOYER

CITY

STATE

ZIP CODE

DATES OF EMPLOYMENT

TYPE OF BUSINESS

FROM:

TO:

NAME OF SUPERVISOR/REFERENCE

TELEPHONE NUMBER

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

C. LICENSES:

Type of License(including specialty)	Institution Granting License and Address	Date Received	Expiration Date

D. EDUCATIONAL HISTORY (College and Subsequent Education):

Institution	Address	Attended from/to	Degree	Date Received

E. HISTORY OF ANY LEGAL ACTIONS:

1. Have you ever changed your name or used an alias?

YES ☐ NO ☐

NOTE: If "YES," attach an explanation including other names(s) date(s) and the reason(s) for each change.

2. Except for minor traffic violations, have you ever been indicted or been convicted or had a sentence imposed or suspended, or been pardoned of a conviction for any crime?

YES ☐ NO ☐

3. Are there any criminal actions pending against you?

YES ☐ NO ☐

4. Have you ever been named as a defendant in any civil action or proceeding in which there was an issue of moral turpitude, including but not limited to fraud or breach of fiduciary responsibility?

YES ☐ NO ☐

NOTE: If "YES" to 2, 3, or 4, attach explanation(s) including the date of the action or proceeding, place (county of the filing), the civil docket number, if available, and the disposition of the case, if any.

5. Have you ever been an owner, officer, trustee, management employee or controlling stockholder of an entity which, while you occupied any such position or served in any such capacity with respect to it:

- a. suffered the suspension or revocation of its certificate of authority or license to do business in any state?

YES ☐ NO ☐

- b. was denied a certificate of authority, license or contract to do business in any state?

YES ☐ NO ☐

NOTE: If "YES" to any of the above, attach an explanation.

II. AFFILIATION WITH OTHER HEALTH CARE OPERATIONS:

INSTRUCTIONS: The purpose of this section is to obtain a complete listing of any health care operations with which the owners, officers, directors, executives or medical director of the proposed External Review Agent have been affiliated within the past 10 years. Affiliation with health care operations for the purposes of this section includes serving as an officer, director, member of the management staff, stockholder of 10 percent or more of stocks or key advisor for the health care operation.

1. For the past 10 years, have you owned or operated any health care or health related operations or held a management position or had any affiliations with health care or health related operations in New Hampshire, in the USA or in other countries?

YES

☐

NO

☐

NOTE: If "YES," complete the following chart:

Name & Address of Health Care Corporation	Affiliation Dates From/To	Nature of Affiliation with Facility	Agency Licensing	License #

VII. AFFILIATION WITH OTHER HEALTH CARE OPERATIONS(continued)

2. Are/were these health care operations in compliance with applicable laws and regulations during your affiliation?

YES

☐

NO

☐

NOTE: If "NO," complete the following: (attach additional pages if necessary)

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name & address)

STEPS TAKEN BY FACILITY TO REMEDY VIOLATION

Has suspension, revocation or accreditation since been restored?

YES

☐

NO

☐

NOTE: If "NO," give an explanation.

3. Has this applicant or any of its holding companies operated as an Independent Review Agent for any other state?

YES

☐

NO

☐

In that capacity as an Independent Review Agent, have you been cited for any violation, deficiency, or improper conduct?

YES

☐

NO

☐

NOTE: If "YES," list all completed, current or pending actions.

VIII. PERSONAL FINANCIAL INVOLVEMENT:**A. Financial Support for the Proposed External Review Agent:**

Is the applicant, owner, all members of a partnership or owners, directors and executives of for profit and not-for-profit corporations or other business corporations intending to provide capital for use in owning, organizing or operating proposed Independent Review Agent? (Controlling person means any person who has the ability, directly or indirectly, to direct or cause the direction of the management or policies of a corporation, partnership or other entity).

YES ☐ NO ☐

NOTE: If "YES," provide the following:

- Attach a personal financial statement for each individual providing financial support from personal finances for the proposed agent;
- Make clear the percent of the business which each person controls, and document its value;
- Lessors are to attach documents showing their financial ability to fulfill any construction obligations;
- Any additional information pertinent to determination of either the applicant's financial capabilities or the project's feasibility must also be attached; and
- For a change in ownership control, submit affidavits from both the applicant and the party from which the operational interest is being acquired. Interest, for the purposes of this section, means right, title or share in a facility, participation in any advantage, profit and responsibility from or for the facility.

B. Transactions with the Proposed External Review Agent or Holding Company:

Have any transactions involving money, extension of credit, liens, notes, bonds or mortgages occurred or are such transactions anticipated between the proposed External Review Agent and you or any of your relative(s) or between the holding company and you or any of your relatives(s)?

YES ☐ NO ☐

NOTE: If "YES," complete the Disclosure of Transactions Form below identifying such transactions.

DEFINITIONS:

RELATIVE, for the purposes of this section, means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse or sibling's spouse.

TRANSACTION, for the purposes of this section, is any business transaction or series of transactions which during any one fiscal year represents 5 percent of the total annual operating expenses of any of the parties to the transaction. Transactions include any sale or leasing of any property. Salaries paid to employees for services provided in the normal course of their employment are not included in this definition. No single transaction of less than \$500 need be reported.

VIII. PERSONAL FINANCIAL INVOLVEMENT: (continued)**DISCLOSURE OF TRANSACTIONS FORM**

PARTIES INVOLVED IN TRANSACTION

TYPE OF TRANSACTION

VALUE OF TRANSACTION

PERCENT OF OPERATING COSTS/

DOLLARS

PERCENT INTEREST RATE/

DOLLARS

REASON FOR TRANSACTION

METHOD OF REPAYMENT

PARTIES INVOLVED IN TRANSACTION

TYPE OF TRANSACTION

VALUE OF TRANSACTION

PERCENT OF OPERATING COSTS/

DOLLARS

PERCENT INTEREST RATE/

DOLLARS

REASON FOR TRANSACTION

METHOD OF REPAYMENT

(Attach additional sheets if necessary)

IX. AFFILIATIONS OF HOLDING COMPANY OR PARENT ENTITY:

INSTRUCTIONS: This section is to be completed by a holding company proposing to sponsor or own the applicant Independent Review Agent.

Using the following form, list all health care or health related operations, institutional or non-institutional, that have been operated, owned or otherwise controlled during the past 10 years by the sponsoring or owning holding company.

Name of Operation & Location	Type of Operation	Date Licensed	Name and Address of Contact Person in State Regulatory Agency

(Attach additional sheets if necessary)

IX. AFFILIATIONS OF HOLDING COMPANY OR PARENT ENTITY: (continued)

1. Are all the operations listed above in compliance with applicable state laws and regulations?

YES ☐ NO ☐

NOTE: If "NO," provide or attach an explanation including the date and nature of the violation, the plan of correction or other resolution.

2. Has the holding company, ever been subjected to financial penalties or suspension or revocation of its operating certificate or license or contract because of failure to comply with provisions governing its conduct and operation?

YES ☐ NO ☐

NOTE: If "YES," complete for each violation.

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

AFFIDAVIT

(to be completed with Sections VI, VII, VIII and IX)

State of _____

County of _____

I, _____ being duly sworn deposes and says
Name (Last, first, middle initial)

I am the _____ of
Position

Organization/Corporation

I certify that I have provided all the information requested in Sections VI, VII, and VIII, and IX including a complete list of any and all health care operations with which the owners, officers, directors, executives, or medical director of the proposed Independent Review Organization have been affiliated within the past 10 years.

I certify, under penalty of perjury, that if no names of such health care operations have been provided, I have had no such affiliations in the past 10 years and that the information contained in Sections VI through IX is accurate, true and complete.

Signature _____ Date _____

Subscribed and sworn to before me this

_____ day of _____, _____

Name of Notary Public _____

Signature of Notary Public _____

ATTACHMENT A
Independent Review Agent Provider Listing

For each clinical peer reviewer and medical director of the Independent Review Agent, complete the following information. Identify potential Conflicts of Interest for each reviewer.

Name	State and License No. (s)	Clinical Specialty	Practice Affiliations	Research Focus (if Applicable)

The above information is accurate and complete for all participating peer reviewers and the medical director of the Independent Review Organization.

CEO Signature _____

Notary public

ATTACHMENT B

Conflict of Interest Attestation

To be executed by the CEO on behalf of the corporate entity, owners, officers, directors, medical director and management employees of the applicant.

For purposes of this attestation, "material familial interest" means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

"Material financial interest" means any financial interest more than five percent of total annual revenue or total annual income of an Independent Review Agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any independent review. The term material financial interest shall not include revenue received from a health care plan by an Independent Review Agent to conduct an independent review.

"Material professional interest" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial interest with any expert or any officer or director of the organization.

I. Whereas, the applicant for certification as an Independent Review Agent shall not own or control, be owned or controlled by, or exercise common control with any of the following:

1. a health carrier;
2. a national, state, or local trade association of health carriers; or
3. a national, state, or local trade association of health care providers; and

II. Whereas, no Independent Review Agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any independent review, shall have any material professional affiliation, material familial affiliation, material financial affiliation, or other affiliation proscribed pursuant to regulation, in relation to an independent review, with any of the following:

1. the health carrier that is the subject of the external review;
2. any officer, director, or management employee of the health carrier that is the subject of the external review;
3. the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
4. the facility or institution at which the recommended health care service or treatment would be provided;
5. the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review; or
6. the covered person or the covered person's authorized representative; and

III. Whereas, the following organizations are not eligible for certification to conduct external reviews:

1. professional or trade associations of health care providers;
2. subsidiaries or affiliates of such provider associations;
3. health carrier or health plan associations; and
4. subsidiaries or affiliates of health plan or health carrier associations.

Now, therefore, _____ in my capacity as Chief Executive Officer of the applicant, _____
(Name of Chief Executive Officer) (Applicant)

do attest and affirm under penalty of perjury that _____ has no disqualifying relationship as described in Section I above,
(Applicant)

and further, that neither _____ nor any of its owners, officers, directors, medical director, management employees,
(Applicant)

or clinical peer reviewers currently employed or engaged have any material affiliation (as defined above) with any person or entity listed in Section II above except as indicated on the attached sheet(s) incorporated and made as part hereof; and further that _____ is not one of the
(Applicant)
types of organizations listed in Section III above.

Name of Chief Executive Officer _____

Signature _____

Date _____

Notary Public _____